

Insights for Implementers

Improving Access to Maternal Health Care through Insurance

Issue in brief

In developing countries, more than 500,000 women die every year from complications related to pregnancy and childbirth (World Bank 2001: 13). Many other women suffer pregnancy- and delivery-related complications that result in long-term health problems. A woman's death during childbirth often means death for the newborn, and both deaths and disabilities translate into emotional, social, and economic hardships for women's older children, their entire families, and even their communities.

Maternal and infant deaths can be prevented by ensuring that high quality maternal and newborn health care is accessible and that maternal health complications are recognized, referred, and treated by a skilled health care worker. However, many women lack the financial means to pay for basic medical care, or they are deterred from seeking care by cultural barriers such as the status of women within the family and in society. They may postpone their own

treatment when sick in order to pay for care for family members, or they may not seek care at all.

In recent decades, health organizations and programs around the globe have dedicated appreciable resources to improve women's and children's health, including their access to effective care. Continuing high maternal mortality ratios suggest that, despite these efforts, maternal health care is not effectively reaching the poor, due in part to the way it has been financed and delivered. Exhibit 1 shows that, in Rwanda and Bolivia, use of modern contraceptive services, antenatal care, and professional assistance during delivery are low, which has contributed to high maternal and infant mortality rates.



Photo: Ricardo Bltrán



Exhibit 1: Maternal Health Indicators in Rwanda and Bolivia

Indicator	Rwanda DHS 2000	Bolivia DHS 1998
Contraceptive prevalence rate, modern methods, all women	2.7%	16.5%
Percentage of women with at least 1 antenatal care visit	92%	69%
Percentage of women with assisted delivery by a health professional	31%	56.7%
Percentage of women with assisted delivery by a physician	8%	52.9%
Maternal mortality ratio, per 100,000 live births	1,071	1,379
Infant mortality rate, per 1,000 live births	107	67.3

Sources: For Rwanda: Office National de la Population et ORC Macro 2001; for Bolivia: Instituto Nacional de Estadística y Macro International Inc. 1998.

Note: DHS = Demographic and Health Survey

The United Nations has agreed on eight Millennium Development Goals to be attained by 2015. One goal is to reduce the maternal mortality ratio by 75 percent. Two indicators have been suggested to monitor the achievement of this objective:

- Maternal mortality ratio; and
- Proportion of births attended by skilled health personnel.

The U.S. Agency for International Development aims to increase women's use of maternal health interventions through improved access to and availability of quality maternal health and nutrition programs and services. Activities to reach this goal include mobilizing and educating communities for good health practices; strengthening the provision of antenatal care; immunizing mothers against tetanus; preventing, detecting, and treating anemia, malaria, and sexually transmitted infections; ensuring safe delivery and postpartum care; and providing care for obstetric complications.

Poor women in particular tend to be excluded from health care by barriers that are difficult to overcome. Among them are cultural and educational barriers that prevent women from revealing their pregnancy and using maternal care, as well as the lack of quality care in health facilities. In addition, high user fees and other costs of seeking care, and weakly defined and implemented fee exemption mechanisms cause many poor women to limit their medical service use. Health insurance has been proposed as one alternative to address these financial barriers, aiming to increase individuals' use of health interventions and to protect them from being

"Membership in a prepayment scheme allows seeking care promptly when sick, without losing time trying to borrow money from friends in order to pay for medical services."

—Rwanda prepayment scheme focus group participant

pushed further into poverty due to illness. When properly designed, health insurance has been successful in decreasing financial barriers to health services and increasing utilization of services (in some cases, especially among the poor), and it can contribute to increasing efficiency and quality of care over time.

This *Insight for Implementers* presents the experience of two different health insurance systems and their impact on women's access to health care. The following sections introduce the concept of health insurance and its applications in middle- and low-income countries. Two case studies on health insurance that cover maternal health are presented: a national insurance plan for mothers and children in Bolivia and prepayment schemes in Rwanda. Key findings are presented on the performance of the two systems to assess whether they contribute to women's well-being by increasing their access to care. The last section contains lessons learned and guidance for policymakers and implementers.

Definitions

Health Insurance

Health insurance is a mechanism that protects the insured against the risk of the financial consequences of an uncertain illness or accident. The individual insured is protected because individual risk of illness or accident is pooled with the risk of other insurance scheme members. Because there is little probability that all members will fall sick within a short period of time, the group minimizes individual risk. Insurance funds, which can be paid by private

and/or public sources, are used to purchase a medical benefit package from providers, to which the insured have access when sick. Thus, health care providers “supply” care to patients who “demand” care; but a third party – the insurer – pays the provider. When in need of care, the insured pay less than the full amount of medical expenses, allowing them to obtain more medical care than would be possible without insurance.

In many countries, health insurance has proven to be a valuable tool to improve access to care and respond to overall equity and sustainability goals in the health sector. Additional research is needed on health policy implications of insurance strategies.

Picking the Right Type of Health Insurance

Health insurance may take different forms. Exhibit 2 summarizes the four most common types: (1) community-based,¹ (2) commercial, (3) employer-sponsored, and (4) government-owned social health insurance.

Commercial and publicly organized insurance schemes depend on a formal employment sector and are more common in middle- and high-income societies. In some developing countries, problems related to information and contract enforcement limit the effectiveness of formal financial and insurance markets. This has caused the poor to devise their own pooling mechanisms; among them is prepayment (or community-based) health insurance.

¹ The terms community-based health insurance, prepayment schemes, and *mutuelles* (mutual health organizations) tend to be used interchangeably.

Exhibit 2: Overview of Insurance in Low- and Middle-Income Countries

Ownership	Financial contributions	Enrollment	Service arrangement	Predominant geographic areas
Community-based health insurance, prepayment plans, or <i>mutuelles</i>				
Owned by their members, an NGO, or health facility	Premiums by individual members or by cooperatives, such as farmers' associations	Voluntary. Persons join as individuals, by household, or in groups	Directly through their staff and facilities or contracted with providers	Africa and increasingly among the poor, informal sector, workers in low/middle-income countries in Latin America and Asia
Commercial insurance				
Owned by private insurance company	Regular personal participation fees of enrollees (premiums)	Voluntary. Persons join individually or in groups	Contracted mainly with private providers	Latin America middle-income countries, middle/high-income groups in Africa and Asia
Employer-sponsored health plans				
Owned by employer	Payroll deduction from formal sector employees and employer contributions	Voluntary, but can be compulsory for employees within an organization	Employer-owned health facilities or contracted with providers	India, Chile, Honduras, Liberia, Democratic Republic of Congo, and other countries
Social health insurance				
Owned by government	Funded by payroll deduction from formal sector employees and government sources	Often compulsory universal coverage for formal sector employees	Mainly public health facilities or contracted with providers	Middle-income countries in Asia, Latin America, and the Middle East/North Africa; and middle-income groups in Africa

Source: Adapted from World Bank 1992

Critical Issues

exclude many low-income groups, who often are economically active in the informal sector.

The Importance of Good Design

Good design is critical to the sustainability and equity of insurance schemes, because it prevents insurance features that create perverse behavioral incentives for the insurer, providers, and the insured. Many community-based schemes have emerged without access to outside technical assistance that could help ensure sound design. In some cases, the result is financial problems that bankrupt the scheme. In other cases, equity goals are sacrificed to ensure the insurer's financial viability, i.e., increases in premiums and co-payments pay for medical cost increases but exclude the poor from enrollment. Insurance plans that operate only in the formal employment sector also

How Insurance Design Affects Behavior

As noted above, certain insurance design features create perverse behavioral incentives. Health insurance design flaws lead to adverse selection and moral hazard by the insured, over-supplying of care by the provider, and "cream skimming" by the provider and insurer.

- *Adverse selection* refers to the fact that primarily the sick enroll. This creates insurance pools with enrollees who use medical care frequently, resulting in financial problems for the scheme. Voluntary and individual enrollment may trigger adverse selection, as they allow



sicker individuals to enroll more often than healthier ones.

- *Moral hazard* occurs when the insured use medical services frivolously, i.e., more often than is medically necessary.
- Provider payment mechanisms may contain incentives to *over-supply* or *under-supply* care:
 - With fee-for-service, the insurer pays the provider a negotiated rate per service provided to the insured patient. This payment mechanism encourages providers to deliver more care than needed, e.g., to provide more services than is medically necessary or to exceed the average length of hospital stay.
 - With capitation, the insurer pays the provider a lump-sum payment based on the number of members in the insurance plan, regardless of patients' service use. Capitation may cause providers to limit services to insured patients, even when the services are medically necessary.

- *Cream skimming* occurs when the insurer or provider tries to exclude high-cost individuals (those with existing illnesses or conditions) from insurance enrollment and from treatment.

Exhibit 3 summarizes common design flaws of insurance plans and mechanisms that limit their effect. Those mechanisms are discussed below.

How to Avoid or Limit Shortcomings of Insurance Design

Understanding the perverse incentives often associated with health insurance helps to design an insurance system that limits these shortcomings and, in addition, promotes access to care for the poor.

- Making insurance enrollment compulsory avoids adverse selection by the insured and cream skimming by the insurer. In voluntary schemes, adverse selection and cream skimming can be limited by imposing group and household enrollment categories, and by requiring that the membership period cover a fairly long period, such as a year.

Exhibit 3: Avoiding Shortcomings Associated with Insurance

Shortcoming	Insurance mechanisms that contribute to shortcomings	Insurance mechanisms that avoid or limit shortcomings
Adverse selection Cream-skimming	Voluntary and individual enrollment	Compulsory enrollment, household and group enrollment Waiting period before service use
Moral hazard Over-supplying care	No co-payment by insured Fee-for-service provider payment	Co-payment Capitation provider payment Monitoring quality of care
Under-supplying care	Capitation provider payment	Monitoring quality of care Risk-adjusted capitation payment Incentives to increase utilization, particularly of preventive services



- Where women lack financial access to health care, group and household enrollment ensure that the whole household is covered.
- Charging insured patients a co-payment when they use medical care can discourage moral hazard.
- Women with little schooling are more confident about paying a fixed co-payment amount than calculating a co-payment as a percentage of their health care bill.
- Capitation payment, payment based on the number of members enrolled in an insurance scheme, can limit providers' over-supplying of care. This type of payment places the financial risk of insurance on providers and encourages them to be more productive. Risk-adjusted capitation payment adjusts the payment for the provider's patient case-mix, resulting in higher provider payments for more severely ill patients.
- Patients may not know whether their provider treats them according to standard treatment protocols. Monitoring providers' quality of care limits the potential under-supplying of care that may occur with capitation payment.

Insurance design features affect everyone in the health sector. Some features may remove financial barriers for the middle- and upper-income groups, but fail to do so for the poor. Some, such as enrollment categories, may have different consequences in different contexts. For example, the value a society attributes to women or children may affect their insurance enrollment. Where resources are scarce, men

may be entitled to individual enrollment before women and children. The objective in the design phase is to anticipate and counter-balance perverse incentives, to ensure that the health insurance design respond to overall health policy goals.

Case Studies

Social Insurance in Bolivia

Bolivia is one of the poorest countries in Latin America. The 1992 population and housing census showed that 70 percent of the population is poor. Despite continued government efforts to provide access to health care, utilization of formal health services remained low particularly among the poor. In 1994, only 42 percent of deliveries occurred within health facilities – the lowest rate in Latin America – and 25 percent of the population was not covered by any of the various health sub-systems – public, NGO, or private.

Health Financing Reform

In 1996, as part of a broader health reform strategy, the government of Bolivia created the SNMN (Spanish acronym for National Insurance for Mothers and Children) to increase health service utilization by reducing economic barriers, for example, by eliminating user fees. Services covered under the SNMN included: prenatal care; pre-eclampsia; eclampsia; vaginal delivery with neonatal care; Cesarean section with neonatal care; postpartum sepsis; postpartum hemorrhage; neonatal asphyxia, pneumonia, and sepsis; acute respiratory illnesses; and diarrhea for children under age five.

The SNMN was financed by municipal funds. In 1994, Bolivia instituted a decentralization law allocating 20 percent of national revenues to municipalities on a per capita basis; 85 percent of the funds allocated to each municipality had to be spent on what was termed “investment purposes.” Starting in 1996, with the onset of the SNMN, 3.2 percent of those investment monies was earmarked for health and assigned to a fund from which each municipality would draw to pay participating health facilities for drugs, supplies, hospitalizations, and laboratory exams, based on a preset payment schedule.

The SNMN was a first step towards achieving the ultimate goal of universal insurance coverage. As a next step towards this goal, in 1999, the SNMN was incorporated into a Basic Health Insurance (SBS) plan by expanding the package of services in partnering health facilities and the population covered.² Facilities initially participating in SNMN were primarily Ministry of Health (MOH) facilities. The SBS expanded the participation to social security and not-for-profit providers as well.

Results

The Partnerships for Health Reform (PHR) project conducted an evaluation using data from facility records and provider and patient surveys to assess the insurance program’s financial sustainability, administrative structure, and impact on utilization and quality of services. Findings revealed that:

- **Utilization** of formal maternal and child health services covered by the program increased to some extent with the implementation of the SNMN (Exhibit 4).³ This increase can be attributed to the SNMN because it exceeds the rate of increase in utilization of non-covered services and services delivered by non-participating providers. Utilization rose markedly for institutional deliveries and pneumonia in children under five and among the poor and adolescents, a group previously under-utilizing formal health services (Exhibit 5). A recent household survey revealed that utilization by the poorest group increased less than by other groups, perhaps due to cultural or geographic rather than financial barriers, and this should be further examined.

Exhibit 4: Growth in Utilization after the SNMN

(comparing 18-month period prior to SNMN and 18-month period following SNMN implementation)

Services	Public	Social Security	NGOs	Private
Total prenatal visits	39%	16%	94%	-50%
Other outpatients	29%	34%	61%	-56%
Total deliveries	50%	43%	28%	-37%
Other inpatients	26%	18%	47%	-29%

Source: Dmytraczenko et al. 1999.

² In January 2003, the SBS was converted into the SUMI (Spanish acronym for Universal Health Insurance for Mothers and Children).

³ Comparison of 1994 and 1998 DHS findings show improvements in utilization rates of key maternal health services in Bolivia (from 42.3 to 55.9 for the percentage of women with assisted delivery by a physician; 52.5 to 69.0 for the percentage of births receiving prenatal care from a doctor or nurse) (Instituto Nacional de Estadística y Macro International, Inc. 1998).

Exhibit 5: Distribution of SNMN Clients by Socio-Economic Level and Age, and Percentage Whose Last Delivery was in the Home

	Public		Age	Previous Delivery at Home
	Low	Middle	14 to 20	
Maternity	68%	32%	25%	31%
Prenatal	76%	24%	30%	24%
Other outpatient	74%	26%	18%	14%

Source: Dmytraczenko et al. 1999.

Note: Due to the lack of socio-economic data prior to the implementation of SNMN, before and after comparisons of utilization based on socio-economic level are not possible.

Nonetheless, issues related to the appropriate public-private mix still need to be addressed as provision of services free-of-charge to all who demand them may and indeed has led to a shift toward the public sector and away from the private sector. In a resource-constrained setting such as Bolivia, there needs to be consideration of how to effectively target public sector subsidies to those who can least afford to pay.

■ **Quality of care** has improved in primary health care facilities, where drugs and supplies are now more readily available. Although patients report a high level of satisfaction, some providers expressed concern about not being able to respond adequately to the increased patient load, especially in some tertiary facilities.⁴ Findings suggest that in participating social security facilities, quality of care differs depending on whether patients belong to the social security system or are covered under the SNMN. There is some evidence that SNMN-insured patients are being discriminated against in terms of the amenities they receive, their length of hospital stay, the number of beds available to them, and, in some cases, the treatment they are prescribed.

■ **Financial results** show that reimbursement rates do not cover actual costs incurred by the facility. The reasons are manifold. Reimbursement rates set under the SNMN are homogeneous across facility types, while costs are generally higher in tertiary facilities that deliver more complex treatment. In some cases, key inputs were excluded from the rate calculation; in others, inputs were under-priced. Also, many health care facilities do not follow the MOH standard treatment protocols on which reimbursement rates have been based.

While the SNMN has had many successes in terms of increasing utilization of formal maternal and child health services by the poor, certain issues must still be addressed. Some hospitals have erected artificial access barriers by requiring insurance patients to present an SNMN card or other documents, such as birth certificates, before receiving services. Some patients were asked to purchase SNMN-covered drugs, perhaps because drugs were not available due to stock-outs at facilities. The absence of co-payments under SNMN has led patients to seek care in higher-level facilities, where they perceive the quality of care to be better, even if the severity of their condition does not warrant care at that level of the service delivery network (for example, prenatal care in tertiary hospitals). These findings have led to policy recommendations.

⁴ Although SNMN has led to greater use of the existing public health infrastructure, evidence suggests that hospitals are still operating below full capacity.



Next Steps

PHR made the following recommendations to improve the SNMN performance:

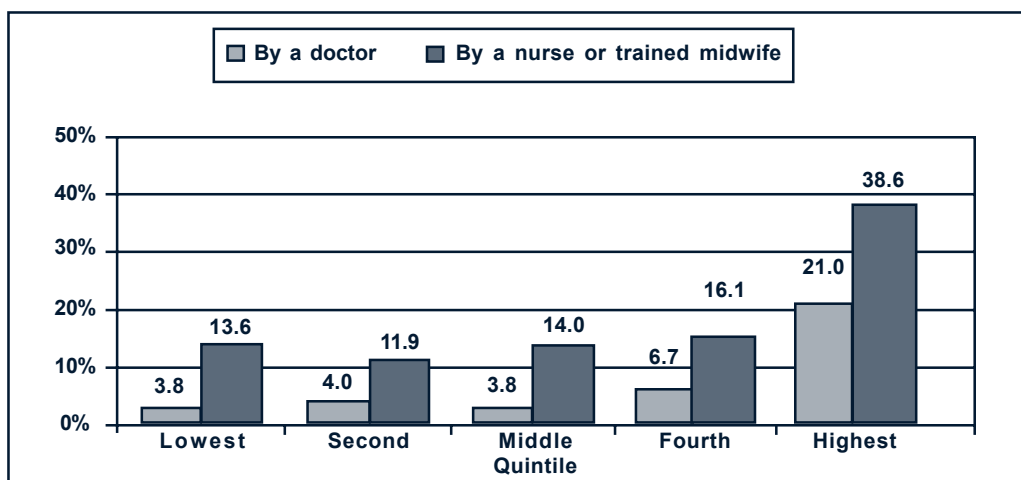
- **Improve efficient service use** by reinforcing the “gatekeeper function” in the referral system, encouraging patients to seek care in appropriate-level facilities. This may require measures such as improving quality at the primary level, setting progressively higher co-payments across the service delivery network, and introducing bypass charges in cases where adequate referral was not sought.
- **Improve quality of care** by setting incentives to motivate medical personnel by rewarding efficiency and good quality care.
- **Increase the effectiveness of financing** by differentiating reimbursement rates across the various levels of the service delivery network to reflect actual costs with respect to the level of complexity of the institution.

- **Increase financial control** by adopting a cost accounting system within each facility that generates the information to adjust the SNMN reimbursement rates and to continuously evaluate facility performance.

Prepayment Schemes in Rwanda

In Rwanda, about 70 percent of the population of eight million lives below the poverty line. In 1996, diminishing public revenues caused health facilities to re-introduce user fees to patients to generate supplemental revenues. As a result, utilization of basic health care dropped from 0.3 annual consultations per capita in 1997 to a national average of 0.25 in 1999. As shown above in Exhibit 1, only 31 percent of all Rwandan women are assisted by a medical professional when giving birth. Women in the lower four socio-economic quintiles are considerably less likely to receive assistance than are those in the highest quintile (Exhibit 6).

Exhibit 6: Delivery Assistance in Rwanda, by Income Quintile



Source: Household Living Condition Survey, 2000.



The Rwandan Ministry of Health decided to address low service utilization by pilot-testing prepayment schemes (PPS) for basic health care to assure utilization of health interventions by the poor. PHR provided technical and financial support during the entire pilot phase (1998-2000).

Developing PPS

A strongly participatory approach, with active citizen involvement, was used to design, implement, and manage the PPS. On a central level, a steering committee, headed by the MOH Director of Health Care, was created to coordinate the pilot phase. The committee selected three of the country's 40 health districts – with three hospitals and 54 health centers serving a rural population of about one million – to participate in the pilot. In the three districts, representatives from the communities and the health sector met in 28 workshops, while citizens met in a series of community gatherings.

This participatory process built organizational and human capacity and resulted in the creation of the insurance design, and legal, contractual, financial, and administrative tools to manage a health insurance fund. Nearly 300 workshop participants who live in the three rural districts were trained to manage the finances and administration of 54 PPS. Each prepayment plan partnered with a health center. At the end of the four-month design phase, the district population started to enroll in the prepayment plan associated with their “preferred” health center.

PPS Features

As suggested by the local population in the three districts, PPS membership covers a basic health care package including deliveries, essential drugs, and curative and preventive care services provided by nurses in a preferred health center; as well as ambulance transfer to the district hospital, where a limited package of benefits, including Cesarean section, is covered with health center referral.⁵

Several insurance features in the PPS design aim to avoid shortcomings commonly associated with insurance plans:

- **Organization:** According to Rwandan law, the PPS are legal associations managed and owned by their members. Social cohesion of members encourages operational transparency of the schemes.
- **Enrollment category:** Households that wish to be insured pay at the time of enrollment a premium of RWF 2,500 (US\$ 7.50 in July 1999) to cover a family of up to seven persons for one year.

“PPS member women go to the health center because they can afford to pay the co-payment of 100 francs. But a non-member woman has to ask the man in the family for money to pay the fees for care, which is particularly difficult if the man is traveling.”

—Rwanda prepayment scheme focus group participant

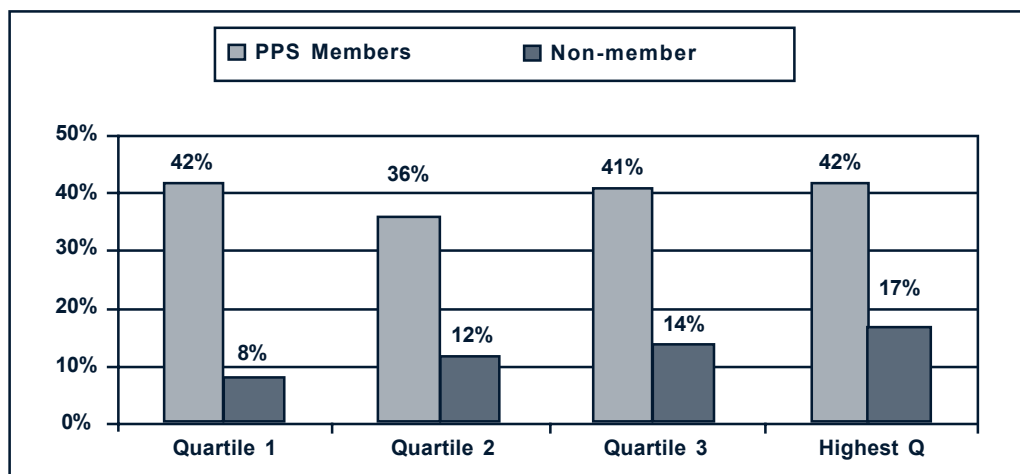
⁵ For example, district hospital coverage in the Kabgayi district PPS covers full episodes of Cesarean sections, malaria, and non-surgical pediatrics. In Kabutare and Byumba, PPS cover full episodes of Cesarean sections, while physician consultations and overnight stays are covered for all other diagnoses.

- **Provider payment:** PPS funds are managed by the PPS executive bureau and pooled by all members. Each month, each PPS bureau disburses one-twelfth of its accumulated premium fund: Eighty-five percent of the amount is paid to the partnering health center on a capitation basis. Ten percent is paid to the district's PPS federation, which reimburses the hospital on a fee-for-service basis. (The remaining 5 percent is withheld to cover the scheme's administrative costs.)
- **Waiting period:** After a waiting period, members who feel they need medical care first contact their preferred health center.
- **Co-payment:** Members pay a RWF 100 (US\$ 0.3 in July 1999) co-payment for a health center visit. Health centers function as a gatekeeper to dissuade members and providers from frivolous use of more expensive hospital services.
- **PPS membership** in the 54 PPS at the end of the first year (June 2000) was 88,303 individuals, approximately 8 percent of the target population. Local churches paid enrollment fees for about 3,000 members, among them widows and their children, and orphans. Although at a slower pace than during the first year, membership continued to grow, and, by November 2002, the schemes had more than 150,000 members. However, about 85 percent of the population in the three districts has not yet enrolled. Non-members cite poverty as the main reason for not enrolling.
- **Utilization** of medical services by the insured increased to approximately four times that of uninsured individuals. Exhibit 7 shows that PPS membership has led to equal access across all socio-economic groups. Among the uninsured, the poorest report the lowest utilization rates. This is largely due to patients' inability to pay user fees. Ten percent of uninsured patients also said they did not have the money to buy drugs prescribed during the health center visit.

Results

Based on data from health centers, hospitals, PPS, households, focus groups, and patient exit interview surveys, PHR evaluated the PPS impact on medical service use, quality of care, and financing:

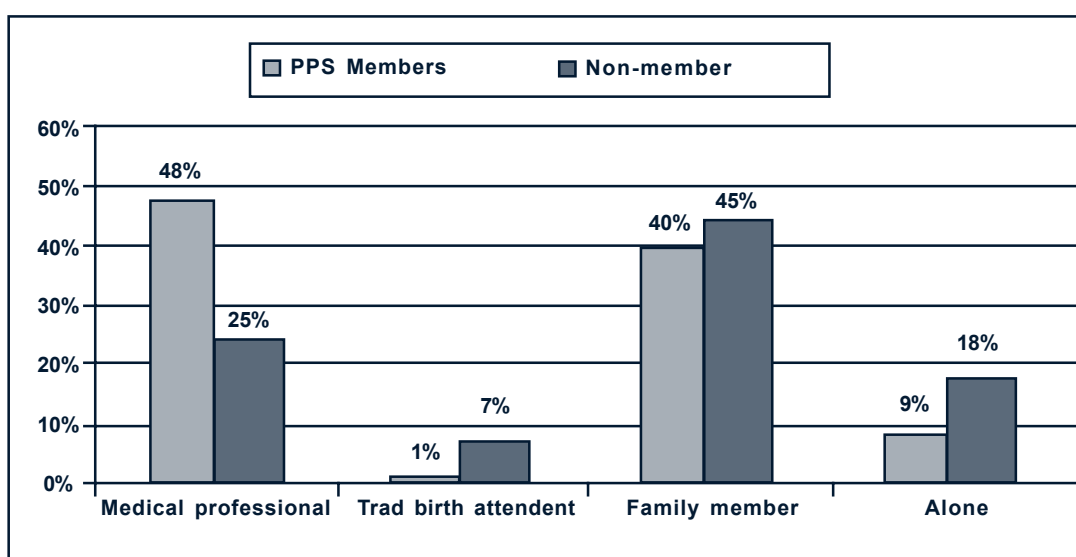
Exhibit 7: Proportion of Sick Individuals Who Reported at Least One Visit with a Professional Provider, by Insurance Status and Socio-economic Quartile



Source: Schneider and Diop 2001

- **Quality of care**, as expressed by preventive care and skilled birth attendance, has improved. Insured women are considerably more likely to have one to three prenatal care visits. With no associated co-payment, insured women report markedly higher use rates for Cesarean section at the district hospitals. Patients, independent of their insurance status, reported satisfaction with care. Exhibit 8 shows that insured women are almost twice as likely to deliver with professional assistance compared to the uninsured. In this way, the PPS have the potential to be an effective tool to guarantee access to safe motherhood.
- **Subsidize membership premiums** for vulnerable groups. The example of churches paying the enrollment fees of target groups such as widows and their children, and orphans demonstrates the value of developing a formal mechanism to use public funds to subsidize premiums for the poorest households.
- **Improve efficiency of service provision.** Increased PPS enrollment – and a resultant increase in health facility usage – should lead to better use of currently underutilized resources. This can be achieved by creating incentives, for example, a salary component for medical personnel, that reward improved efficiency.
- **Improve quality of care** by, similar to the preceding point, creating incentives that motivate medical personnel, in this case to improve the quality of care.
- **Increase financial control** by adopting a cost accounting system within each health facility that generates information to monitor the performance of finances, service use, and quality control.
- **Build capacity** by continuously training PPS and health facility managers on the financial management of their organizations. This is particularly important where literacy rates are high.

Exhibit 8: Delivery Assistance, by Insurance Status



Source: Schneider and Diop 2001



Guidance and Lessons

Experience in Bolivia and Rwanda shows that financing reforms, particularly in the form of health insurance, can lessen constraints to financial access to health care, and increase utilization of maternal health services by poor households. However, insurance must be carefully designed to avoid shortcomings that could limit its effectiveness. Other countries may benefit from the lessons learned in Rwanda and Bolivia when considering health insurance as a key component of health financing reforms.

- The *organizational and legal form* of the health insurance needs to be embedded within the country's socio-economic context.
 - In a country with a socio-economic context similar to Bolivia, expanding social insurance to the informal employment sector may improve medical service use among those who have been excluded from social health insurance.
 - In a very poor rural environment that lacks access to formal insurance, like Rwanda, a prepayment scheme managed and owned by its members may be a suitable alternative financing mechanism. Whereas formal insurance often excludes poor people from decision making, the poor can use PPS premiums as a tool to negotiate with health care providers for better quality care, shorter waiting times, more staff, and better equipped health facilities.
- The insurance *design phase* is particularly important to ensure that the insurance scheme responds to overall sustainability and equity objectives – for example, that it effectively reaches intended target populations (mothers, children, the poor) – and avoids or limits shortcomings associated with most insurance mechanisms. Participatory design processes build local capacity to plan and manage insurance, provide a forum for low-income citizens to express their health needs and negotiate benefits, and increase accountability among insurers, providers, and the insured.
- Because PPS serve a population that is poor and often illiterate, continuous financial and technical assistance, especially *human and organizational capacity building*, are necessary. With proper inputs and guidance, communities can develop the necessary technical skills to own and manage their insurance plans effectively. Insurers and providers also need to develop the human and organizational capacity to manage the flow of insurance funds.
- *Monitoring and evaluation* of the performance of providers and insurers is important to continue to improve and refine insurance mechanisms, to ensure that insurance effectively responds to its members' health needs, to avoid shortcomings associated with insurance, and to expand coverage to new segments of the population or new geographic areas over time. Evaluation efforts in Bolivia revealed that, while overall utilization increased due to SNMN, it increased less for the lowest-income group than for others. This information can help identify shortcomings of the insurance design and lead to refinements that correct the shortcomings.



Both country experiences show that there is a *need to secure public resources* to subsidize premiums and health care for the poor, and to guarantee continuous and equitable health financing and service use through health insurance. In resource-constrained settings such as Bolivia and Rwanda, there needs to be consideration of how to effectively target public sector subsidies to those who can least afford to pay.

PHRplus Tools and Tips

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Insights for Implementers: Improving Access to Maternal Health Care through Insurance

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